IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 1, 2009

Rex Redden
Idaho Falls Group Home #4 Summit
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #4 Summit, provider #13G071

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #4 Summit, which was conducted on May 21, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 15, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 15, 2009. If a request for informal dispute resolution is received after June 15, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP - Team Lead Jim Troutfetter, QMRP Common abbreviations used in this report are: IDT - Interdisciplinary Team ITTP - Interdisciplinary Treatment Team Plan NOS - Not Otherwise Specified QMRP - Qualified Mental Retardation Professional RN - Registered Nurse	W 000	RECEIVED JUN 17 2009 FACILITY STANDARDS	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided privacy during treatment and care of personal needs for 1 of 6 individuals (Individual #4) residing at the facility. This resulted in an individual receiving a medical examination from the facility's RN with his bedroom door open. The findings include: 1. Individual #4's 5/2/09 Physician's Orders stated he was a 20 year old male whose diagnoses included cerebral palsy, anxiety disorder, autistic behavior, and severe mental retardation. During an observation on 5/18/09 from 4:05 - 5:00	W 130	W-130 1. All individuals have the potential to be affected by this practice. The RN consultant has been trained on the privacy practices of Idaho Falls Group Homes and indicated she has a full understanding of what needs to occur. 2. The QMRP will do follow up and on going training to ensure that privacy is maintained for all individuals in the homes. 3. Target date for completion will be July 21, 2009.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Andrea Toles — Admin. Assistant — 6/12/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 1 p.m., the facility's RN was noted to arrive to complete a physical examination on Individual #4. The RN had staff take Individual #4 into his bedroom, which was located directly off the living room of the facility. The RN proceeded to complete a physical examination of Individual #4 while the bedroom door remained open. A direct care staff was in the room with Individual #4 and the RN. The RN asked questions of the staff regarding Individual #4's health, grooming and toileting practices, which the staff answered. During the examination, 3 other individuals, 2 direct care staff, and the survey team were located in the main living area of the home and had a clear view of Individual #4 inside his bedroom. Additionally, the questions being asked of the direct care staff by the RN regarding Individual #4's health matters could be overheard. When asked during the observation, the RN stated she had left the door open in case the surveyors wanted to observe the examination. When asked about the examination, the staff member present in the bedroom with Individual #4 stated the door should have been shut to protect Individual #4's privacy. Additionally, the Lead Worker of the facility, who was present during the observation, stated the door to Individual #4's bedroom should have been shut during the examination. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the Medical Coordinator stated the RN should have closed Individual #4's bedroom door during the examination to protect his privacy.	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 2 The facility failed to ensure Individual #4's privacy was protected during a medical examination.	W 130		
W 152	483.420(d)(1)(iii) STAFF TREATMENT OF CLIENTS The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure employees received a thorough background check, which had the potential to negatively impact 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure had the potential to allow staff with prior convictions of abuse, neglect or mistreatment to work with individuals residing at the facility. The findings include: 1. The facility's "Policy for Background Check Completion," revised 7/15/08, outlined the facility's procedure for completing self declarations and criminal background checks. A review of the facility's personnel records documented the following concerns: a. The Policy stated employees were to attend an orientation class within the first 7 days of employment at which time a self declaration and application for a fingerprint based criminal history check was to be completed. The policy stated "all copies of the Self Declaration will be signed and notarized before it goes into the file."	W 152	W 152 1. All individuals have the potential to be affected by this practice. A Human Resource position has been implemented to ensure background checks are being scheduled and that employees are attending the appointments. A form has been created which indicates the employee's date of hire, the date the background check was scheduled for, the date the background check was completed, the date the clearance letter was printed, and the date the clearance letter was filed in the employee file. The Background Check Policy will be revised to include and/or delete all changes made to the background check procedure. 2. The Human Resource employee will be responsible for monitoring the background check procedure. The QMRP will complete a weekly follow-up with the Human Resource employee and will initial and date the form that has been created to indicate that follow-up has been completed. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 152	Continued From page 3 - Staff A's personnel file documented she was hired 2/20/09. Her personnel file contained two self declaration and applications for fingerprinting, dated 2/26/09 and 3/5/09. However, both self-declarations and applications were unsigned and un-notarized. - Staff B's personnel file documented he was hired 1/13/09. However, his personnel file included an unsigned and un-notarized self declaration and application for a background check. - Staff C's personnel file documented he was hired 11/25/08 and was terminated on 1/21/09. However, his personnel file included an unsigned and un-notarized self declaration and application for a background check. - Staff E's personnel file documented he was hired 12/6/08. However, his personnel file did not include a self declaration and application for a background check. - Staff F's personnel file documented she was hired 3/1/09. However, her personnel file did not include a self declaration and application for background check. Without completion of the initial screening steps of signing a self declaration and application for a background check, the facility would not be able to ensure persons with disqualifying convictions were precluded from working. The facility failed to ensure staff completed, signed, and had notarized a self declaration and application for background check.	W 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 152	Continued From page 4 b. The Policy stated an appointment to be fingerprinted would be made at the time the staff completed the self declaration and application for a background check. The Policy stated "If the employee then misses his/her appointment they will be put on suspension until they reschedule the fingerprinting and have completed their fingerprinting." - Staff A's personnel file documented she was hired 2/20/09. Her personnel file contained two self declaration and applications for fingerprinting, dated 2/26/09 and 3/5/09. Additionally, her personnel file documented she missed fingerprinting appointments for both applications. However, the facility's as worked schedule documented Staff A worked continually from her hire date until she completed fingerprinting on 4/21/09. The facility failed to ensure Staff A was suspended from working with individuals following her missed fingerprinting appointments. c. The Policy stated "Weekly checks of the manual will be done by the Administrator Designee to ensure follow up is happening for the applications. Follow up will occur weekly until a clearance letter or denial letter is received from the Department." There was no documentation weekly checks had been completed. Without a review process being implemented, the facility would not be able to identify and correct issues with missed appointments and failure to complete applications. That failure created the potential for persons with disqualifying convictions to work with individuals residing at the facility.	W 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 152	Continued From page 5 When asked during an interview on 5/20/09 from 1:15 - 1:20 p.m., the Administrator stated the reviews had not been taking place due to an oversight. During an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated the facility's Policy for Background Check Completion was not being followed as written. The facility failed to ensure all staff received thorough screening for staff to prohibit the employment of individuals with convictions or prior employment histories of child or client abuse, neglect or mistreatment.	W 152		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 1 of 3 individuals (Individual #3) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #3's 6/25/09 ITTP stated he was a 21 year old male whose diagnoses included schizophreniform disorder, pervasive developmental disorder, and mild mental retardation.	W 214	W 214 1. All individuals have the potential to be affected by this practice. The QMRP has contacted the psychiatrist for clarification on proper programing needed for the diagnosis that each individual has. The assessment and program plan will then be revised as directed to meet the needs of each individual. 2. The treatment team will review all assessments and plans at each treatment plan meeting or as needed to insure that assessment and program plans are meeting the needs fo each individual. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 6 Individual #3's Behavior Assessment, dated 6/10/08, stated the following: a. The "Description of Behavior" section included "Frustration," defined as yelling, screaming, going to his bedroom, blocking doors so others could not get into the room, running down stairs to get away from a situation, locking himself in a craft room, leaving the facility and running around a 4 block radius, threatening staff with harm, being rude, swearing, making fun of people, and hitting others. Under the "Function" section of Individual #3's Behavioral Assessment it stated frustration occurred when Individual #3 did not want to do something, did not understand things, thought someone was talking about him, wanted attention, or was paranoid about people stealing things. Individual #3's Plan Sheet titled "Decrease Frustration," dated 9/26/05, stated talking seemed to help Individual #3 work off some of the "anxiousness he is having." Individual #3's Behavioral Assessment did not include "anxiousness." b. The "Description of Behavior" section included "Odd behaviors," defined as paranoia, hearing voices, thinking others are mean to him, misinterpreting staff direction as being screamed at or forced to complete tasks, and thinking things have happened that have not. The assessment stated "These behaviors can be a number of different things and something different each time." Under the "Function" section, the Behavioral	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 7 Assessment stated "There does not seem to be precursors for this behavior...He has however said on different occasion [sic] that he done [sic] it for attention or that the voices tell him to do it." Individual #3's Plan Sheet titled "Odd behaviors," dated 1/30/06, stated any time Individual #3 was showing signs or symptoms of his schizophrenia staff were to talk with him to help him "work through the difficult time and help him to make good choices." The signs and symptoms were on an attached tracking sheet and included the following: - difficulty enjoying activities that he usually enjoys - lack of emotion - loss of motivation to accomplish goals - problems focusing or paying attention - difficulty processing information - confusion or fragmented thoughts - hearing voices - false beliefs - bizarre or disorganized behavior or angry outbursts - self neglect - isolating himself more than usual - inappropriate emotions - terror or unreasonable fear With the exception of false beliefs, self neglect, and inappropriate emotions, the tracking sheet did not provide a description of the signs and symptoms to be tracked. Additionally, it was not clear why the signs and symptoms listed on the tracking sheet were not included in the Behavioral Assessment. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Individual #3's Behavioral Assessment did not	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 8 clearly define odd behavior and how it was related to his diagnoses of schizophrenia. The QMRP stated the Behavioral Assessment needed to be revised. c. The "Description of Behavior" section included "Fabricated stories," defined as "telling stories." Individual #3's Behavioral Assessment did not include a description of fabricated stories. In addition, the "Description of Behavior" section of the Assessment stated fabrication happened for three reasons: if he was asked to do something and thought he had done something wrong, if he was angry with someone else, or if he thought it was true because of his schizophrenia. The "Settings" section of the Assessment stated fabrication happened when he was trying to impress someone, when he wanted attention, when he thought he was in trouble, or when he was angry. The "Function" section of the Assessment stated fabrication happened when he wanted attention from people around him. It was not clear what function of fabrication was accurate. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Individual #3's fabrication program had been discontinued as fabrication only happened when he was having problems with other issues, such as his schizophrenia. The QMRP stated Individual #3's Behavioral Assessment needed to be updated. d. The "Description of Behavior" section included "Sleeping," defined as getting up several times during the night or early in the morning and not wanting to go back to bed. The Behavior	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 9 Assessment stated Individual #3 "has a difficult time sleeping due to his diagnosis," but did not state what diagnosis. Additionally, the "Function" section of the Assessment stated "There is no antecedents for this behavior as we never know when it will happen." However, Individual #3's Medication Reduction Plan, dated 6/25/08, stated he was to receive "Trazadone [sic] 50 mg at bedtime to aide in the sleep disturbances caused by his schizophrenia." However, the schizophrenia symptoms (hearing voices, terror or unreasonable fear, etc.) which prevented him from sleeping were not identified. Without comprehensive assessment information regarding which schizophrenia symptoms were preventing Individual #3's sleep, it would not be possible for the IDT to develop adequate intervention strategies (i.e., symptom management strategies vs sleep hygiene practices). The facility failed to ensure Individual #3's Behavioral Assessment contained comprehensive and accurate information.	W 214		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was	W 239	W 239 1. All individuals have the potential to be affected by this practice. All behavior management plans will be reviewed and revised to incorporate replacement behaviors for all inappropriate behaviors. 2. The QMRP will review all behavior plans to ensure replacement behaviors are in place for all inappropriate behaviors. The QMRP will monitor monthly with monthly review. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 10 determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior management plan for 1 of 3 individuals (Individual #3) whose behavioral interventions were reviewed. This resulted an individual not receiving training to replace his maladaptive behaviors. The findings include: 1. Individual #3's 6/25/09 ITTP stated he was a 21 year old male whose diagnoses included schizophreniform disorder and mild mental retardation. a. Individual #3's record included a Plan Sheet titled "Odd behaviors," dated 1/30/06, which stated staff were to track signs and symptoms of schizophrenia. However, his record did not include information related to training he was receiving to appropriately identify, compensate, or cope with his signs and symptoms of schizophrenia. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Individual #3 did not have a replacement behavior program for odd behavior. b. Individual #3's record included a Plan Sheet titled "Decrease Frustration," dated 9/25/05, which stated staff were to talk with Individual #3 when he was getting frustrated. However, the record did not include information related to training he was receiving to appropriately replace his maladaptive behavior. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Individual #3 did not have a replacement behavior	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 11 program for frustration. The facility failed to ensure a Individual #3 received training to appropriately replace his maladaptive behaviors.	W 239		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' ITTPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without a plan that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's 10/30/08 ITTP documented a 35 year old male whose diagnoses included autistic tendencies, profound mental retardation, and stereotypic movement disorder. Individual #1's Medication Reduction Plan, dated 10/30/08, documented he received Celexa (an antidepressant drug) 35 mg, Mellaril (an antipsychotic drug) 10 mg in the morning then 50	W 312	W 312 1. All individuals have the potential to be affected by this practice. The QMRP has contacted the psychiatrist for clarification on which medications are tied to which behavior symptoms. The medication reduction plan has been revised to indicate the psychiatrists recommendations for which medications are tied to which behaviors, diagnoses, and symptoms for which they are prescribed. The medication reduction plan has also been revised to indicate which objective must be met prior to a reduction being attempted. 2. The QMRP will be responsible for monitoring behavioral objectives monthly. If criteria is met on the behavioral objective that is tied to the medication reduction plan, a recommendation for a medication reduction will be made to the individuals treatment team and psychiatrist. If criteria is met on the behavioral objective, the medication reduction plan will be reviewed and revised as needed. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 12 mg in the evening, and Campral (a miscellaneous antagonist) 333 mg twice a day for stereotypic behavior with the potential for self injury. Individual #1's Medication Reduction Plan included two objectives, one to decrease stereotypic behavior and one to decrease agitation. However, it was not clear why the plan included criteria for decreasing agitation when none of the medications were prescribed for agitation. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated all 3 medications were for stereotypic behavior and she was not sure the agitation criteria should be in the medication reduction plan. The facility failed to ensure Individual #1's Medication Reduction Plan included clear and accurate information related to the reduction and eventual elimination of the behaviors for which the drugs were employed.	W 312		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the pharmacist conducted comprehensive drug regimen reviews with accurate input from the treatment team for 1 of 4 individuals (Individual #4) whose pharmacy consultations were reviewed. This resulted in the potential for negative health outcomes due to supplements not	W 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 362	Continued From page 13 being included in the review for potential interactions with other drugs. The findings include: 1. Individual #4's Physician's Orders, dated 5/2/09, documented a 30 year old male whose diagnoses included cerebral palsy, severe mental retardation, anxiety disorder and seizure disorder. During an observation on 5/19/09 from 7:10 - 8:10 a.m., Individual #4 was noted to receive the following: - Glycolize (a supplement). - Electroform (a supplement). - Livplex (a supplement). - Alsculus (a supplement). - Metex (a supplement). - Calcium Lactate (a supplement). - Gaba (a supplement). - Renafood (a supplement). Individual #4's Pharmacy Review, dated 5/6/09, 1/21/09, 10/22/08 and 7/16/08 included an entry that stated "Supplements as prescribed by [physician's name]." However, the Pharmacy review did not list what the supplements were or how many supplements were prescribed or their dosages. Without knowing what supplements Individual #4 was taking, it would not be possible to evaluate them for potential adverse drug interactions. When asked during an interview on 5/21/09 at 2:24 p.m., the nurse stated the Pharmacist would have no way of knowing about possible drug interactions if the supplements were not listed on the Pharmacy Review form.	W 362	W 362 1. All individuals have the potential to be affected by this practice. All medications and supplements will be individually listed on the pharmacy review form so that the treatment team and pharmacy consultants can accurately determine interactions for all medications to ensure there are no potential adverse drug interactions. 2. The Medical Coordinator will review all pharmacy review forms prior to the pharmacy review meetings to ensure that all medications and supplements are included on the pharmacy review form. The treatment team and pharmacy consultants will review the pharmacy review forms during quarterly meetings to ensure that there are no potential adverse drug interactions. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 362	Continued From page 14 The facility failed to ensure all supplements were reviewed by a Pharmacist for Individual #4.	W 362		
W 388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure all supplements were correctly labeled for 1 of 5 individuals (Individual # 4) observed during a medication pass. This resulted in the potential for medication administration errors and subsequent negative impacts to Individual #4. The findings include: 1. Individual #4's Physician's Orders, dated 5/2/09, documented a 30 year old male whose diagnoses included cerebral palsy, severe mental retardation, anxiety disorder and seizure disorder. During an observation on 5/19/09 from 7:10 - 8:10 a.m., Individual #4 was noted to receive the following: - Glycolize (a supplement). - Electroform (a supplement). - Livplex (a supplement). - Alsculus (a supplement). - Metex (a supplement). - Calcium Lactate (a supplement). - Gaba (a supplement). - Renafood (a supplement). The Electroform, Glycolize, Calcium Lactate, Renafood and Livplex were noted to be in a bubble pack with Individual #4's name hand	W 388	W 388 1. All individuals have the potential to be affected by this practice. The Medical Coordinator will contact the Chiropractor responsible for prescribing the supplements to discuss labeling issues for all supplements being prescribed. 2. The Chiropractor will be responsible for labeling all supplements prescribed to an individual. The Medical Coordinator will be responsible for ensuring that all supplements are labeled correctly once they have been delivered. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 388	Continued From page 15 written on the front cover. The Gaba, Alsculus and Metex were noted to be in bottles that had no name on them. The bubble pack and bottles did not have pharmacy labels and did not include the dosage or time Individual #4 was to receive the supplement. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the nurse stated a chiropractor sends the supplements to the facility and she fills the bubble packs. She further stated the supplements were not filled by the pharmacy. The facility failed to ensure all drugs and biologicals were labeled according to professional practice for Individual #4.	W 388		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure there was an active program for the prevention and control of communicable diseases. This failure directly impacted 2 of 2 individuals (Individuals #2 and #4) observed at the facility's day treatment program, and had the potential to impact 4 of 4 individuals (Individuals #1 - #4) who attended the facility's day treatment program by providing opportunities for cross-contamination to occur between individuals and negatively impact their health. The findings include: 1. During the entrance conference on 5/18/09 from 11:30 a.m. - 12:25 p.m., the QMRP stated	W 455	W 455 1. All individuals have the potential to be affected by this practice. All employees will be retrained on infection control practices, policies and procedures. 2. The supervisor of each facility will be responsible for immediately retraining all employees on infection control, prevention, and investigation of infection and communicable diseases. The supervisor of each facility will be responsible for providing on-going training to all employees on infection control practices, policies and procedures during their monthly staff meetings. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 16 Individuals #1 - #4 attended the facility's day treatment program. An observation was conducted at the facility's day treatment program on 5/19/09 from 9:50 - 10:45 a.m. During that time the following concerns were noted in the room attended by Individual #2 and Individual #4: - An individual from another facility was noted to have a runny nose. During the observation, a staff member repeatedly assisted the individual to wipe his nose, then assisted other individuals in the room, including Individual #2 and Individual #4, with tasks without washing or sanitizing her hands. Additionally, the staff member provided edible reinforcements to no less than 3 other individuals in the room. Those reinforcements were located in her pocked in a plastic bag, and in a cabinet in a plastic bag. The staff would remove the reinforcements with her bare hands and provide them to the individuals, including Individual #2 and Individual #4. - Individual #2 was observed to be working with a packaging project. Individual #2 was noted to repeatedly place his hand in his pants and scratch his buttocks, as well as scratch his nose. Individual #2 would then touch the items to be packaged and place them in their appropriate containers. When the individual finished the task, a staff placed the items on a shelf. Another staff removed the same items and provided them to two separate individuals from another facility. The staff did not sanitize the items prior to providing them to other individuals. - Individual #2 was observed to be placing lids of varying sizes on containers. During the course of	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 17 the task he would place the lids or containers against his mouth. Upon completion of the task, the staff gathered the items and provided them to another individual from a different facility. The items were not sanitized prior to being provided to the other individual. - Individual #4 was observed to have staff comb his hair. Once the staff completed combing Individual #4's hair, she reached into a bag with her bare hands and provided Individual #4 with an edible reinforcement. - A staff was observed to have a ball-point pen in her hair. The staff would repeatedly remove the pen from her hair to document activities in the room, and then replace the pen in her hair, touching her hair repeatedly in the process. The staff was not observed to wash or sanitize her hands during the course of the observation. The staff was observed to provide multiple edible reinforcements to individuals within the room with her bare hands. - A second staff was observed to repeatedly use her hands to sweep her hair behind her ears. The staff was not noted to wash or sanitize her hands during the course of the observation. The staff was noted to handle items individuals had been manipulating and placing in their mouths, pass the items to other individuals, and provide edible reinforcements to individuals within the room. When asked about infection control practices, the two staff present during the observation stated staff were trained to wash and sanitize individuals' hands, and desks, tables and chairs were wiped down with bleach solution each night. When	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 18 asked about the practices observed, staff stated they should have washed or sanitized their hands while working with individuals, and should have sanitized items prior to providing them to other individuals. Both staff stated they had not realized items were being placed in individuals' mouths, and did not think about washing their own hands prior to touching edible reinforcements. The day treatment Supervisor, who was present during the observation, stated items should have been sanitized and staff should have been washing their hands frequently. The Supervisor stated more training needed to be completed. The facility failed to ensure infection control practices, including hand washing and sanitization of activity items, were implemented at the day treatment program.	W 455		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM066	16.03.11009 Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Criminal History and Background Check. An intermediate care facility for the treatment of individuals with mental retardation must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08) 02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08) a. Federal Bureau of Investigation (FBI); (3-26-08) b. Idaho State Police Bureau of Criminal Identification; (3-26-08) c. Sexual Offender Registry; (3-26-08) d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08) e. Nurse Aide Registry. (3-26-08) 03. Availability to Work. Any direct patient access	MM066	MM066 Refer to W 152 RECEIVED JUN 17 2009 FACILITY STANDARDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM066	Continued From page 1 individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any resident. (3-26-08) 04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08) 05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08) a. Accepting employment with a new employer; and (3-26-08) b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08) 06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08) a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08) b. The employer has documentation of the criminal history and background check findings; (3-26-08) c. The employer completes a state-only background check of the individual through the	MM066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM066	Continued From page 2 Idaho State Police Bureau of Criminal Identification, and (3-26-08) d. No disqualifying crimes are found. (3-26-08) 07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08) This Rule is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure staff working with clients received fingerprint based criminal history and background check within 21 days of their hire date, which had the potential to negatively impact 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure had the potential to allow staff to work at the facility without sufficient criminal history screening. The findings include: - Staff A's personnel file documented she was hired 2/20/09. Her personnel file contained two self declaration and applications for fingerprinting, dated 2/26/09 and 3/5/09. However, both self-declarations and applications were unsigned and un-notarized. Her filed did not include information that a background check had been completed within 21 days of her hire date. - Staff B's personnel file documented he was hired 1/13/09. However, his personnel file included an unsigned and un-notarized self	MM066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM066	Continued From page 3 declaration and application for a background check. His filed did not include information that a background check had been completed within 21 days of his hire date. - Staff C's personnel file documented he was hired 11/25/08 and was terminated on 1/21/09. However, his personnel file included an unsigned and un-notarized self declaration and application for a background check. His filed did not include information that a background check had been completed within 21 days of his hire date. - Staff D's personnel file documented she was hired 2/11/09. Her file contained an application for a background check, dated 3/10/09, and a clearance letter was not received until 4/15/09. Her filed did not include information that a background check had been completed within 21 days of her hire date. - Staff E's personnel file documented he was hired 12/6/08. However, his personnel file did not include a self declaration and application for a background check. His filed did not include information that a background check had been completed within 21 days of his hire date. - Staff F's personnel file documented she was hired 3/1/09. However, her personnel file did not include a self declaration and application for background check. Her filed did not include information that a background check had been completed within 21 days of her hire date. During an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Staff A - F did not receive their background checks within the 21 day period after their hire dates.	MM066		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM066	Continued From page 4 The facility failed to ensure all staff completed the required background check within 21 days of their hire date.	MM066		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	MM197 Refer to W 312	
MM203	16.03.11.075.12(a) Treated with Consideration Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W130.	MM203	MM203 Refer to W 130	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include:	MM380	MM380 1. All individuals have the potential to be affected by this practice. All employees are responsible for completing a damage report on all repairs that are needed in the facility. The damage report is then turned in to the supervisor for review. The supervisor then submits the damage report to the QMRP for follow-up. 2. All repairs that are needed will be completed by maintenance personnel. 3. Target date for completion will be July 21, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 5 An environmental survey was conducted on 5/19/09 from 2:05 - 2:25 p.m., and the following concerns were noted: - The left bolt was missing from the base of the toilet in the bathroom by the living room. - The shower wall was cracked in the bathroom by the living room, and there was mold around the shower edges. - Individual #3's closet door was detached and leaning against his bedroom wall. - There was a knob missing from the drawer of Individual #5's dresser. - The rocking chair in Individual #2's bedroom was missing slates in the back and had a broken rocker rail. - The patio light was not working. - The light above the dining room table was missing a globe. - The floor strip for Individuals #2 and #6's closet entrance was held down with masking tape. - The refrigerator was missing a shelf rail in the door, and the shelf rail in the freezer was broken.	MM380		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 Refer to W 214	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G071	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #4 SUMMIT	3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM730	Continued From page 6	MM730		
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362.	MM758	MM758 Refer to W 362	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	MM769 Refer to W 455	
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W239.	MM855	MM855 Refer to W239	